| IPDR6702 | | | | NORTH CAROLINA | | PAGE: | 1 | |
|-----------|--------------------------------|-------------|-----------|--|---------|----------|-----------|--------|
| RUN DATE: | 02/11/2007 | | | HECKWRITE SUMMARY REPORT | | FAGE: | - | |
| | | | | KWRITE DATE: 02/13/2007 | | | | |
| | 1 | 1 | F | 'INANCIAL PAYER: NCDMH | | | | |
| | | | | | | | TOTAL | TOTAL |
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404901 | SMOKY MOUNTAINM | 8505 | 7880 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | H/DD/SAS | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 11 | 798 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | 11 | 790 | DATE | 0 | 9433 | 9434 | 1 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8800 | | FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON | | | | |
| | | | | FUTURE RA'S. | | | | |
| | | | | | | | | |
| 3404904 | WESTERN HIGHLAN | 8534 | | SERVICE FACILITY LOCATION IS N | | | | |
| | DS LME | | | OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F | | | | |
| | | | | | | | | |
| | | 8505 | | CLAIM DENIED DUE TO INSUFFICIE | 0 | 1076 | 10201 | 9125 |
| | | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 191 | 121 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| 3404910 | DATHWAYC | 8599 | 351 | DETAIL NOT COVERED BY COMBINAT | | | | |
| 3101310 | PATHWAYS | 0333 | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8536 | | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT | 65 | 640 | 9826 | 9186 |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | | | | | | | |
| | | 8654 | 46 | ONLY 16 UNITS ALLOWED PER DAY | | | | |
| | | | | WITHOUT PRIOR APPROVAL. PLEASE CORRECT THE | | | | |
| | | | | | | | | |
| 3404912 | CATAWBA COUNTYM | 8508 | 4 | CLAIM DENIED NO BUDGET FOUND | | | | |
| | ENTAL HEALT | | | | | | | |
| | | | | | | | | |
| | | 8537 | 3 | PROCEDURE IS NOT PAYABLE FOR Y | 0 | 7 | 659 | 652 |
| | | | | OUR PROVIDER TYPE AND | - | | | |
| | | | | SPECIALTY IN ACCORDANCE TO MEN | | | | |
| 3404913 | | 11 | 3103 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| 3101313 | MECKLENBURG COM ENTAL HEALT | | 3103 | DATE | | | | |
| | ENTAD HEADT | | | | | | | |
| | | | | | | | | |
| | | 8599 | | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | 7 | 3712 | 7398 | 3686 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 120 | 133 | CLIENT ID NUMBER MISSING OR IN | | | | |
| | | | | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| | | | | | | | | |
| 3404916 | CROSSROADS BEHA | 8518 | 593 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| - | VIORAL HEAL | | | FILING TIMELIMIT. PRIOR | - | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | 8505 | 97 | CLAIM DENIED DUE TO INSUFFICIE | 0 | 859 | 2873 | 2014 |
| | | | | NT BUDGET | 0 | 059 | 20/3 | 2014 |
| | | | | | | | | |
| | | 8800 | 50 | FURTHER PROCESSING NECESSARY, | | | | |
| | | | | PLEASE CHECK FOR CLAIM ON | | | | |
| | | | | FUTURE RA'S. | | | | |
| 24040 | | 0505 | 010 | | | | | |
| 3404917 | CENTERPOINT HUM | 8505 | 219 | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | | | | |
| | AN SERVICES | | | N1 D0D031 | | | | |
| | | | | | | | | |
| | | 8599 | | DETAIL NOT COVERED BY COMBINAT | 0 | 350 | 4186 | 3836 |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | DENEFII PACRAGE. | | | | |
| | | 143 | 42 | CLIENT ID NUMBER NOT ON STATE | | | | |
| | | | | ELIGIBILITY FILE | | | | |
| | | | | | | | | |
| | 1 | 1 | [| | | <u> </u> | | |

| | | 1 | | | | | mom? * | momar |
|----------|--------------------------------|-------------|-----------|--|---------|---------|-----------|-------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | TOTAL | TOTAL |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| | | | | | | | | |
| 3404919 | GUILFORD CO MEN | 21 | 34 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | TAL HEALTHC | | | | | | | |
| | | | | | | | | |
| | | 8599 | 34 | DETAIL NOT COVERED BY COMBINAT | 1 | 79 | 3330 | 3251 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | 2330 | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 8536 | 4 | ATTENDING PROVIDER TYPE AND SP | | | | |
| | | 8536 | 4 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT | | | | |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | | | | | | | |
| 3404920 | ALAMANCE CASWEL | 8505 | 3303 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | L AREA MH D | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 79 | 351 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | 1 | | 221 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING | 0 | 3876 | 5189 | 1313 |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | | | | | |
| | | 21 | 146 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | - | | | |
| | <u> </u> | | | | | | | |
| 3404921 | onawan nana | 8505 | 2026 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| >#4 | ORANGE PERSON C HATHAM AREA | | | NT BUDGET | | | | |
| | HATHAM AREA | | | | | | | |
| | | | | | | | | |
| | | 5312 | 331 | PRIOR AUTHORIZED DOLLARS EXCEE | 0 | 3473 | 6775 | 2323 |
| | | | | DED | | | | |
| | | | | | | | | |
| | | 21 | 236 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404922 | THE DURHAM CENT | 8000 | 92 | NO RATE AVAILABLE ON FILE TO P | | | | |
| | ER | | | RICE THIS CLAIM DETAIL | | | | |
| | | | | | | | | |
| | | 8505 | 90 | CLAIM DENIED DUE TO INSUFFICIE | 26 | 426 | 6282 | 5856 |
| | | | | NT BUDGET | 20 | 120 | 0202 | 2036 |
| | | | | _ | | | | |
| | | 143 | 7.4 | | | | - | |
| | | 143 | 74 | CLIENT ID NUMBER NOT ON STATE | | | | |
| | | | | ELIGIBILITY FILE | | | | |
| | | | | | | | | |
| 3404923 | FIVE COUNTY MH | 11 | 49 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| | <u> </u> | 21 | 20 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 21 | 28 | DUPLICATE OF CLAIM-SYSTEM | 0 | 172 | 694 | 522 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8536 | 27 | ATTENDING PROVIDER TYPE AND SP | | | | |
| | | | | ECIALTY COMBINATION IS NOT | | | | |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| 3404925 | | 120 | 480 | CLIENT ID NUMBER MISSING OR IN | | | | |
| J 207323 | SANDHILLS CENTE | | 200 | VALID. ENTER CID AND SUBMIT | | | | |
| | R FOR MH/DD | | | AS A NEW CLAIM | | | | |
| | | | | | | | | |
| | | 8599 | 131 | DETAIL NOT COVERED BY COMBINAT | 27 | 903 | 8087 | 7184 |
| | | - | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | ļ | | | BENEFIT PACKAGE. | | | | |
| | <u> </u> | 21 | 80 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404926 | SOUTHEASTERN RE | 8518 | 170 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | G MENTAL HL | | | FILING TIMELIMIT. PRIOR EISCAL VEAR DOS (JULY 1 - JUNE | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | 21 | 76 | DUPLICATE OF CLAIM-SYSTEM | 3 | 347 | 1782 | 1435 |
| | | | | | 3 | 347 | 1/82 | 1435 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 44 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | 1 | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | I . | l . | I . | | 1 | l | ı |

| | | | | | | | TOTAL | TOTAL |
|----------|-----------------|--------------|-----------|--|---------|---------|-----------|--------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404927 | | 0505 | 147 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| 3404927 | CUMBERLAND CO M | 8505 | 14/ | NT BUDGET | | | | |
| | HC | | | NI BODGEI | | | | |
| | | | | | | | | |
| | | 8599 | 43 | DETAIL NOT COVERED BY COMBINAT | | 0 210 | 1003 | 793 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | 0 210 | 1003 | 793 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 191 | 6 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404930 | JOHNSTON COUNTY | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | MNTL HLTHC | | | | | | | |
| | | | | | | | | |
| | | 0 | | | | | | |
| | | U | U | | | 0 0 | 0 | 0 |
| | | | | | | | | |
| 3404931 | | 8599 | 74 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | WAKE CO HUM SVC | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | BILLING OF | + | | BENEFIT PACKAGE. | + | 1 | 1 | |
| | | + | | | | | | |
| | | 8654 | 21 | ONLY 16 UNITS ALLOWED PER DAY | + | 0 179 | 649 | 470 |
| | | + | + | WITHOUT PRIOR | + | 1/9 | 649 | 4/0 |
| | | | | APPROVAL. PLEASE CORRECT THE | | | | |
| | 1 | | | | | 1 | | |
| | 1 | 8534 | 19 | SERVICE FACILITY LOCATION IS N | | 1 | | |
| | | | | OT A VALID IPRS ATTENDING | | | | |
| | | | | PROVIDER. PLEASE VERIFY THE F | | | | |
| | | | | | | | | |
| 3404933 | SOUTHEASTERN CT | 8329 | 1 | CLAIM DENIED ATTENDING PROVIDE | | | | |
| | R FOR MH/DD | | | R CANNOT BE THE SAME AS | | | | |
| | | | | THE LMA | | | | |
| | | | | | | | | |
| | | 0 | 0 | | | 0 1 | 14 | 13 |
| | | | | | | | | |
| | | | | | | | | |
| 3404934 | | 8599 | 267 | DETAIL NOT COVERED BY COMBINAT | | | | |
| 3404934 | ONSLOW CARTERET | 0333 | 207 | ION OF RECIPIENT, PROVIDER AND | | | | |
| | BEHAV HEAL | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 11 | 264 | CLIENT NOT ELIGIBLE ON SERVICE | | 1 936 | 1934 | 998 |
| | | | | DATE | | 1 930 | 1934 | 330 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8535 | 217 | SERVICE FACILITY LOCATION WAS | | | | |
| | | | | NOT SUBMITTED ON THIS CLAIM. | | | | |
| | | | | PLEASE RESUBMIT THE CLAIM WITH | | | | |
| | | | | | | | | |
| 3404935 | WAYNE CO MENTAL | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | HEALTH CTR | | | | | | | |
| | | _ | | | | | | |
| | | 0 | 0 | | | | | |
| | 1 | o . | o . | + | | 0 0 | 0 | 0 |
| | | 1 | | | | | | |
| 3404936 | MIT COM COURSE | 191 | 23 | CLIENT ID NUMBER DOES NOT MATC | | - | | |
| | WILSON-GREENE M | | | H PATIENT NAME | | | | |
| | ENTAL HEALT | - | + | + | | + | | |
| | | + | | + | + | 1 | 1 | |
| | | 8952 | 2 | CLAIM DENIED DUE TO AGE RESTRI | | 1 28 | 2160 | 2132 |
| | | | | CTIONS FOR TARGET POPULATION | | | 2100 | 2132 |
| | | 1 | | | | | 1 | |
| | | | | | | | | |
| | | 79 | 1 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | 1 | | | | | |
| | | | | | 1 | | | |
| 3404937 | EDGECOMBE NASH | 8599 | 13 | DETAIL NOT COVERED BY COMBINAT | | | | |
| 3404937 | EDGECOMBE NASH | 8599 | 13 | ION OF RECIPIENT, PROVIDER AND | | | | |
| 3404937 | | 8599 | 13 | | | | | |
| 3404937 | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404937 | | 8599 8518 | 13 | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND | | 0 32 | 1350 | 1318 |
| 3404937 | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR | | 0 32 | 1350 | 1318 |
| 3404937 | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND | | 0 32 | 1350 | 1318 |
| 3404937 | | 8518 | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE | | 0 32 | 1350 | 1318 |
| 3404937 | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR | | 0 32 | 1350 | 1318 |
| 3404937 | | 8518 | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE | | 0 32 | 1350 | 1318 |

| | | 1 | | | 1 | | | |
|----------|--|--------------|-----------|--|---------|--------------|-----------|-------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | TOTAL | TOTAL |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| | THOUSE THE STATE OF THE STATE O | | | | DIMITIO | DINTILLO | TIMELED | INIE |
| 3404939 | NEUSE MENTAL HE | 8599 | 32 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | ALTH CENTER | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 120 | 4 | CLIENT ID NUMBER MISSING OR IN | | | | |
| | | 120 | 4 | VALID. ENTER CID AND SUBMIT | 0 | 41 | 384 | 343 |
| | | | | AS A NEW CLAIM | | | | |
| | | | | | | | | |
| | | 79 | 2 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | | | | | |
| 2404041 | | 0525 | 22 | PROCEDURE IS NOT PAYABLE FOR Y | | | | |
| 3404941 | PITT CO MH/DD/S | 8537 | 22 | OUR PROVIDER TYPE AND | | | | |
| | AS CENTER | | | SPECIALTY IN ACCORDANCE TO MEN | - | | | |
| | | | | | | | | |
| | | 8599 | 16 | DETAIL NOT COVERED BY COMBINAT | 0 | 90 | 835 | 745 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 7001 | 12 | EXCEEDS THE ONE PER DAY LIMITA TION | | | | |
| | + | + | | | | + | | |
| | | | | | 1 | | 1 | |
| 3404942 | ROANOKE CHOWANH | 21 | 38 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | UMAN SERVIC | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 79 | 4 | THIS SERVICE IS NOT PAYABLE TO | 0 | 44 | 1061 | 1017 |
| | | | | YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | 8518 | 2 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | | | | | |
| 3404943 | ALBEMARLE MENTA | 79 | 30 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | L HEALTH CE | | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | 21 | 26 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 21 | 26 | DOPLICATE OF CLAIM-SISIEM | 3 | 95 | 1569 | 1474 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 16 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| 2404044 | | 01 | 200 | PURI LANDE OF GLAVIA GUARRIA | | | | |
| 3404944 | EASTPOINTE HUMA | 21 | 300 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | N SERVICES | | | | | | | |
| | | | | | | | | |
| | | 8935 | 84 | ASTNC INELIGIBLE TO RECEIVE SE | 104 | 558 | 3051 | 2493 |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8622 | 61 | 60 RESIDENTIAL LEVEL II TREATM | | | | |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| | | | | The state of the s | | | | |
| | | | | 1 | | | | |
| 3404946 | FOOTHILLS AREAM | 143 | 19 | CLIENT ID NUMBER NOT ON STATE | 1 | | | |
| | ENTAL HEALT | | | ELIGIBILITY FILE | | | | |
| | | | | | | | | |
| | | 0526 | 10 | A TOTAL PROGRAMMENT OF THE PARTY OF THE PART | | | | |
| | 1 | 8536 | 12 | ATTENDING PROVIDER TYPE AND SP | 0 | 45 | 3636 | 3591 |
| | | | 1 | ECIALTY COMBINATION IS NOT | | 1 | | |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | 1 |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | 79 | 11 | VALID FOR SUBMITTED BILLING PR THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | 79 | 11 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING | | | | |
| | | 79 | 11 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | | | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | | | | |
| 3404957 | TIDELAND MENTAL | 79 | 277 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE | | | | |
| 3404957 | TIDELAND MENTAL HEALTH CTR | | | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | | | | |
| 3404957 | | | | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE | | | | |
| 3404957 | | 8505 | 277 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | | | | |
| 3404957 | | | | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE | 3 | 305 | 813 | 508 |
| 3404957 | | 8505 | 277 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT | 3 | 305 | 813 | 508 |
| 3404957 | | 8505 8599 | 277 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 3 | 305 | 813 | 508 |
| 3404957 | | 8505 | 277 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE | 3 | 305 | 813 | 508 |
| 3404957 | | 8505 8599 | 277 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 3 | 305 | 813 | 508 |
| 3404957 | | 8505 8599 | 277 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE | 3 | 305 | 813 | 508 |

Sheet1

| | | | | | | | TOTAL | TOTAL |
|----------|-----------------|-------------|-----------|--------------------------------|---------|---------|-----------|--------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| | | | | | | | | |
| 3404979 | NEW RIVER AREAM | 8505 | 301 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | H/DD/SA PRO | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 26 | DETAIL NOT COVERED BY COMBINAT | 0 | 352 | 497 | 145 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 11 | 11 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |